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## OLR Bill Analysis

### sHB 5038

#### ***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING AN ALL-PAYER CLAIMS DATABASE PROGRAM.***

#### **SUMMARY:**

This bill requires the Office of Health Reform and Innovation (OHRI) to establish an all-payer claims database program for receiving and storing data relating to medical and dental insurance claims, pharmacy claims, and information from enrollment and eligibility files from reporting entities. The bill requires insurers or anyone else that administers health care claims and payments ("all payers") to provide information for inclusion in the database. It establishes civil penalties of up to \$1,000 per day for entities that fail to report as required by the bill and implementing regulations.

The bill specifies how OHRI must use the data in the database and makes information in the database broadly available for information relating to health care use, cost, quality, and services. Data disclosure must protect the confidentiality of individual health information.

The bill allows OHRI to independently hire consultants to help it plan or implement the program. It also allows the special advisor to the governor on healthcare reform (who directs OHRI's activities) to contract with an outside entity to implement or administer the program, but she can only do so in consultation with an existing working group that is required by law to develop a plan for a state-wide multipayer data initiative. The bill names the working group the All-Payer Claims Database Advisory Group, expands its membership, and requires it to report on the database program.

The bill also makes technical changes.

EFFECTIVE DATE: October 1, 2012, except the advisory group

reporting requirement is effective upon passage.

## **ALL-PAYER CLAIMS DATABASE PROGRAM**

### ***Program Implementation, Administration, and Purpose***

PA 11-58 established OHRI within the Office of the Lieutenant Governor. OHRI is currently charged with coordinating and implementing the state's responsibilities under state and federal health care reform, among other things, and is under the direction of the special advisor to the governor on healthcare reform.

The bill requires OHRI to oversee the planning, implementation, and administration of an all-payer claims database program for receiving and storing data on medical and dental insurance claims, pharmacy claims, and information from reporting entities' enrollment and eligibility files.

In addition to other contracting authority explained below, the bill creates two different processes for OHRI to enter into private contracts depending upon whether the contract involves planning. It allows the special advisor, in consultation with the All-Payer Claims Database Advisory Group (see below), to contract with another person or entity to implement or administer the program. It also allows OHRI to hire consultants needed to help plan or implement the program, without consulting the advisory group or anyone else.

Under the bill, OHRI's authority to hire consultants to help plan or implement the database program without consulting anyone is an exception to the requirement in current law that OHRI consult with the Sustinet Health Care Cabinet before hiring consultants needed to carry out its duties.

The purpose of the program is the collection, assessment, and reporting of health care information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of health care. Under the bill, OHRI must ensure that data from reporting entities is (1) securely collected, compiled, and stored according to state and federal law and (2) accurate and valid.

The bill allows the special advisor to adopt implementing regulations.

***Reporting Entities***

Under the bill, the following entities are required to provide data to the all-payer claims database:

1. insurers licensed to conduct health insurance business in Connecticut,
2. health care centers (i.e., HMOs),
3. insurers or health care centers that provide state residents with coverage under Medicare parts C or D,
4. third-party administrators,
5. pharmacy benefits managers,
6. hospital service corporations,
7. nonprofit medical service corporations,
8. fraternal benefit societies that transact health insurance business in Connecticut,
9. dental plan organizations,
10. preferred provider networks, and
11. any other individual or legal entity that administers health care claims and payments under a contract or agreement or is required by law to administer such claims and payments.

***Civil Penalties***

The bill subjects reporting entities to civil penalties of up to \$1,000 per day for failing to report as required by the bill or implementing regulations. The bill prohibits reporting entities from passing monetary fines on to rate-setting entities or third-party payers.

While the bill establishes a per day penalty for failure to report, it does not specify when reporting entities must report their data or how often they must do so.

### ***Use and Availability of Data***

The bill requires the special advisor to use the database to provide the state's health care consumers with information about the cost and quality of health care services so that they may make economically sound and medically appropriate health care decisions. She also must make data in the database available to any state agency, insurer, employer, health care provider, health care consumer, researcher, or the Connecticut Health Insurance Exchange (a quasi-public agency created to satisfy requirements of the federal Patient Protection and Affordable Care Act, see BACKGROUND) to allow these people or entities to review the data relating to health care utilization, cost, or service quality.

Any such disclosure must protect the confidentiality of health information as defined in federal Health and Human Services (HHS) regulations (see BACKGROUND) and other information as required by state and federal law.

### ***Fees for Accessing Data***

The bill allows the special advisor to charge a fee to those seeking access to the data in the database.

### ***Grants***

Under the bill, OHRI can accept grants from any source to plan, implement, or administer the database program.

### ***Other Contracting Authority***

The bill allows the special advisor to contract for or take other necessary actions to obtain fee-for-service data under the state medical assistance program or Medicare parts A and B. She may also contract for collection, management, or analysis of data received from reporting entities, but any such contract must expressly prohibit the disclosure of

the data for any purpose other than its collection, management, or analysis under the contract.

## **ADVISORY GROUP**

Current law requires OHRI to convene a working group to develop a plan implementing a state-wide multipayer data initiative to improve the state's use of health care data from multiple sources to increase efficiency, enhance outcomes, and improve the understanding of health care spending in the public and private sectors.

The bill renames the working group the All-Payer Claims Database Advisory Group. It adds to the group's membership the Department of Mental Health and Addiction Services commissioner, the health care advocate, and the state chief information officer. The bill also allows the special advisor to appoint additional members. By law, the group also includes the Office of Policy and Management secretary; the comptroller; the commissioners of public health, social services, and insurance; representatives of health insurance companies; health insurance purchasers; hospitals; consumer advocates; and health care providers.

The bill requires the advisory group, by October 1, 2012, to report on the database program to the governor and the Public Health Committee. The report must include recommendations on (1) the person or entity to implement and administer the database program, (2) a timeline to transfer authority for implementing or administering the program to such person or entity, and (3) program administration.

## **BACKGROUND**

### ***Related Federal Law***

***Affordable Care Act.*** Among numerous other provisions, the federal Patient Protection and Affordable Care Act requires most people to purchase health insurance; makes qualified health plans available through insurance exchanges, which the states must create; and imposes new requirements on group and individual insurance plans.

**HIPAA.** The Health Insurance Portability and Accountability Act's (HIPAA) "privacy rule" sets national standards to protect the privacy of health information. "Covered entities" such as health care providers, health plans (e.g., health insurers, HMOs, Medicare, and Medicaid), and health care clearinghouses must follow HIPAA rules. The HIPAA privacy rule protects individually identifiable health information by defining and limiting the circumstances under which covered entities may use or disclose such information.

**Definition of Health Information.** Under HHS regulations, "health information" means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual (45 C.F.R. § 160.103).

## **COMMITTEE ACTION**

Public Health Committee

Joint Favorable Substitute

Yea 27      Nay 1      (03/29/2012)